CLINICAL CASE STUDY
Format for Written Report of Information

I. PATIENT DATA (completed in full sentences)

A. Facility
B. Date of admission
C. Date first seen by Nutrition Services
D. Date permission was granted to be used as a case study
E. Dates of coverage by participant
F. Attending physician
G. Inter-professional team members

II. NUTRITION ASSESSMENT (completed in full sentences)

A. Client History
   1. Age
   2. Gender
   3. Race/ethnicity
   4. Marriage status/number of children
   5. Language
   6. Education

B. Medical History
   1. Chief complaint
   2. History of present illness. Include changes in patient's condition during period of hospitalization (chronologically)
   3. Medical diagnosis (primary and secondary; identify all disorders)
   4. Description of above disorder(s). Include etiology, pathophysiology, current medical and nutritional treatment modalities
   5. Relationship between nutritional status and above disorder(s). Identify potential and actual relationships.

Medical Diagnosis	Potential Relationship to Nutritional Status	Actual Relationship to Patients Nutritional Status

C. Social History
   1. Living situation
   2. Domestic issues
   3. Social support
   4. Geographic location of home
   5. Occupation

6. Approximate income/retirement/ability to support themselves or others
7. Tobacco, alcohol, drug use
8. Religion

D. Food/Nutrition-Related History
   1. Food & nutrient intake (diet at home or prior to admit)
   2. Food and nutrition knowledge (previous education)
   3. Current appetite and current intake
   4. Food and nutrient administration
   5. Medication/herbal supplement use
   6. Knowledge/beliefs/attitudes
   7. Behavior
   8. Food and supply availability
   9. Physical activity and function
   10. Nutrition-related patient/client-centered measures

E. Anthropometric measurements
   1. Height
   2. Current weight
   3. Admission weight
   4. Usual body weight (UBW) and % UBW
   5. Weight change history – include percent weight change and time frame
   6. Body Mass Index (BMI) and category per World Health Organization (WHO)
   7. Ideal body weight (IBW), % IBW
   8. Growth pattern indices/percentile ranks (pediatrics)
   9. Body compartment estimates (if available)

F. Biochemical Data, Medical Tests and Procedures (and Medications)
   1. Laboratory data

Name of Lab	Normal Range	Patients Value Indicate High or Low	Nutrition Implication

   2. Medications

Medication	Dosage	Indication(s)	Possible Food/Medication Interactions

G. Additional test, procedures or therapies
(Include surgery, physical therapy, occupational therapy, speech therapy, etc.)

Type of test, procedure or therapy	Purpose	Relationship to Nutritional Status

H. Nutrition-Focused Physical Findings
1. Findings from an evaluation of body systems
2. Muscle and subcutaneous fat wasting
3. Skin condition
4. Oral/dental health
5. Suck/swallow/breathing ability
6. Sleep/rest
7. Elimination
8. Exercise, recreation and activity level

Physical Condition	Nutrition Implication	Potential Corrections

I. Estimated Needs
1. Define the patient's nutritional needs in terms of kcals, protein, fluids and any other nutrients deemed appropriate.
2. Use the Evidence Analysis Library or the Nutrition Care Manual to find the best method for determining estimated energy needs. (i.e.: Harris-Benedict, Mifflin-St. Jeor, kcal/kg, etc.). Tell how you estimated needs and include which weight was utilized for calculations (actual, IBW, usual body weight, etc.).
3. Evaluate and analyze current (hospital) intake in terms of energy, protein, fluids and any other nutrients deemed appropriate. Analyze and discuss any deficiencies or excesses.

J. Evaluation of Diet Orders: Complete hospital diet history-include all diet orders from date of admission

Current Nutritional Needs	Current Diet/Supplements (Include TF/TPN/PPN etc)	Is Diet Order Appropriate? Why or Why Not?	Changes Indicated and Supporting Rationale

K. Overall evaluation
   1. Describe the patient's general nutritional status
   2. Provide a thorough rationale for your assessment
      a. What data did you utilize to assess the patient's nutritional status? What guidelines, indicators, criteria, standards factored into your assessment of patients nutritional status?

III. NUTRITION DIAGNOSIS

A. Identify patient's primary nutrition problem using NCP terminology.
B. Identify and prioritize secondary nutritional problems
C. For each nutrition problem, write a PES statement based on the following format. Remember that the intake domain is preferred over clinical or behavioral.

Nutrition Problem related to Etiology as evidenced by Signs/Symptoms

IV. NUTRITION PRESCRIPTION (completed in full sentences)

A. See NT&P Textbook page 66 or Nutrition Care Manual

V. INTERVENTION (completed in full sentences)

A. Based on the ***etiology*** of the nutrition problem, select the nutrition ***intervention*** you feel is most appropriate for the patient. Provide the rationale.
B. Define the most appropriate feeding route to meet patient's nutritional needs and provide clear rationale for selecting such route.
C. Identify nutrition goals for each intervention listed. Be sure to include time frame, if short and long term goals are differentiated.
D. Use the chart below to list and describe each patient intervention or activity you provided, including follow up visits, educational sessions, and conferences with healthcare team, etc. Include the interventions that you recommended.

Date	Intervention/Activity	Expected Outcome

VI. MONITORING AND EVALUATION (completed in full sentences)

A. Based on the signs/symptoms in the PES statement(s), select appropriate indicators to follow.
B. Based on the indicators you are following, select the appropriate criteria you used.
C. What are the possible economic outcomes of the MNT?
    1. Look at the actual costs of the MNT provided and compare to the theoretical savings and actual benefits of MNT provided.
    2. Consider length of stay, re-admission, medication use, infection rate, ventilator use, use of TPN, benefits of weight loss/gain, etc.

VII. HEALTH CARE TEAM (completed in full sentences)

A. Describe precisely how you functioned as a member of the health care team in providing optimal nutritional care for your patient. Do this by indicating your specific interaction with physicians, nursing staff, PA, and any other health professional who participated in the care of the patient. For example, you should be able to show evidence of having talked with the attending physician and team that you were selecting the patient, would be assuming responsibility for the nutritional care, etc. before you begin working with the patient. Additional interactions with the physician(s), nurses, etc. should demonstrate you fully assumed responsibility for nutritional care and communicated routinely with the health care team.

VIII. REFERENCES

A. Provide a bibliography of five or more current (no older than five years) citations related to the diet or disease condition of your patient, which you used to provide optimal care. At least three resources must be peer review journal articles. Consider the following evidence-based sources:
    1. Academy of Nutrition and Dietetics (*AND*) Evidence Analysis Library
    2. *AND* Nutrition Care Manual
    3. *AND* Position Papers
    4. Peer-Reviewed Journal Articles
    5. Text books
B. Utilize the bibliography/reference style used by the *Journal of the Academy of Nutrition and Dietetics* (AMA style)

IX. DOCUMENTATION: Include the following documents with your care study (scan if necessary):

A. All written correspondence with nutritional staff including notification to RD of the patient you selected as your case study
B. Nutrient analysis and calculations - include in appendices if not within the body of the case study
C. Consult report(s) if utilized
D. If available, chart notes with all identifying markers deleted